



CARE ENGLAND
The voice of care

The Financial Health of SME Care Homes

*Working capital, cash resilience and the local
value of England's independent care homes*

With thanks to



October 2026

The Financial Health of SME Care Homes

Working capital, cash resilience and the local value of England's independent care homes

Three reporting points for 2,299 care-home companies, supported by a separate 165-company profit-and-loss calibration cohort.

OCTOBER 2026 · A joint publication by Care England, the Care Association Alliance and the National Care Association

This joint publication examines financial resilience in England's smaller independent care-home companies. It distinguishes filed balance-sheet information, wage and turnover measures estimated using a separate profit-and-loss calibration cohort, external contextual evidence and explicitly illustrative modelling. It does not present a census of SMEs or an audited measure of their profitability.

The report is intended for providers, people drawing on care and their families, the Department of Health and Social Care, HM Treasury, CQC, local government and NHS commissioners. Company-level data is not reproduced. The findings concern cash resilience and payment pressure, not a measured average profit for these companies.

Acknowledgements

The underlying account information originates from Care England's SMART Care Intel portal. Richard Ayres led the report's development. The joint publishers thank David Woodward, Director of Focus Energy Services Ltd, and Michael Butcher, Finance Director of Blackadder Corporation Limited, for their substantial contribution to assembling, testing and interpreting the data. CAA and NCA bring the perspectives of local associations and independent providers to the joint publication.^[1]

Care England's companion reports, Priced to Fail and The Hidden Subsidy, provide the commissioning and funding context. Their findings are cited separately and are not treated as measurements from the SME cohort. This paper covers England only. ^[2, 3]

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ABOUT THIS REPORT

About the joint publishers

Care England

Care England is the largest and most diverse representative body for independent adult social care providers in England and is a registered charity. Its membership ranges from single-site services and small groups to major national and not-for-profit providers, delivering care and support for older people and people with learning disabilities, mental health needs and long-term conditions.

Care Association Alliance (CAA)

The Care Association Alliance is the national umbrella body for local care associations in England. It brings together more than 50 local associations, collectively representing over 10,000 independent care providers across the country, and provides a national voice for locally based providers while sharing intelligence, good practice and local market experience.

National Care Association (NCA)

National Care Association is the most established body representing small and medium-sized providers across independent adult social care, with 45 years of sector representation. Its membership includes local and national provider groups and care associations, with association representatives on its Board. NCA works with local and national government, advocating for providers, their workforce and the people they care for.

ABOUT THIS REPORT

Report development and analysis

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Richard Ayres provides technical and commercial support to Care England on funding, workforce, commissioning challenges and social care reform. He joined Care England in 2021, having worked collaboratively with the organisation since 2014, following a 25-year procurement career across utilities, banking, travel and care. He led the development of this report and the translation of its financial findings into policy and practical implications.

**Michael Butcher****Finance Director, Blackadder Corporation Limited**

Michael Butcher is Finance Director of Blackadder Corporation Limited, a family-owned group of six care homes specialising in residential, nursing and complex dementia care. A Chartered Accountant, Michael combines financial leadership with operational oversight, covering finance, HR, IT, governance and long-term strategic planning. He is an active contributor to the ICAEW healthcare community, writing and speaking on social care finance, taxation, sustainability and the longer-term economics of the sector.

**David Woodward****Director, Focus Energy Services Ltd**

David Woodward is a Director of Focus Energy Services Ltd and Care England's Energy Specialist, supporting providers with energy procurement, cost control, billing analysis and longer-term energy strategy. He brings more than 40 years' experience investigating complex data and financial transactions, alongside specialist knowledge of care and energy markets. Through Focus, he works with Care England and providers nationally to identify overcharging, manage market risk and improve procurement transparency.

JOINT FOREWORD

A shared commitment to the evidence

Smaller care-home providers are part of the fabric of communities across England. They support people through daily relationships, employ local staff and sustain services on which families depend. Care England, the Care Association Alliance and the National Care Association have come together to make that contribution more visible, and to examine the financial conditions required to maintain it.

This report adds evidence about providers outside the main national financial-oversight picture. Filed accounts brought together through Care England's SMART Care Intel portal provide balance-sheet and employee information for 2,299 companies. A separate cohort of 165 companies with profit-and-loss information supplies wage and turnover assumptions. The distinction is important: the smaller cohort calibrates the analysis; it does not establish the profitability of the larger cohort.^[4]

The central finding is that net cash has not kept pace with estimated wage obligations. Mean net-cash cover fell from 2.90 to 2.62 months of estimated wages, while the median fell from 1.33 to 1.23 months. These are relative reporting points, not a single aligned financial year, and the accounts are not a current cash-flow forecast.

In simple terms, cash balances have grown, but not quickly enough to keep pace with estimated wage bills. The middle of the distribution has only a little over one month of estimated payroll in net cash. More value also sits in current assets other than cash, and the modelled collection measure has lengthened. That is a warning about resilience, not proof that every provider is failing.

These are historical accounts. Most latest reporting periods end before the April 2025 employer National Insurance increase, and the wage calibration predates the April 2026 sick-pay reform. The findings therefore do not capture the full later cost burden. Further employment changes from 2027 and the intended April 2028 Fair Pay Agreement increase the importance of adequate, timely funding.^[4]

For residents and families, the significance goes beyond an accounting ratio. A provider with less financial headroom may have fewer options when a payment is delayed, a building needs repair or recruitment becomes more difficult. Sustained pressure can constrain investment and choice well before a service closes. Local employment and purchasing relationships are also part of what communities stand to lose.

The findings complement Care England's Priced to Fail and The Hidden Subsidy reports, which examine fee adequacy and commissioning arrangements. This paper adds a different perspective: how the balance sheets of smaller companies compare with estimated operating obligations. The sources must be read together without treating them as proof of a single cause.^[2, 3]

The joint organisations recognise the financial pressures on councils and NHS commissioners. Their position is that those pressures should not be transferred into unpaid provider invoices. **Care providers are not an interest-free credit facility for the state.** Adequate funding and reliable payment are distinct requirements; improving one cannot substitute for the other.^[5]

Stronger employment rights and the first adult social care Fair Pay Agreement must be accompanied by funding that reaches employers fully and promptly. The government's intended first implementation date is

April 2028. Providers need confidence about both the amount and timing of the funding available to meet new obligations.^[6]

The joint organisations thank Richard Ayres for leading this report, and David Woodward of Focus Energy Services Ltd and Michael Butcher of Blackadder Corporation Limited for the considerable expertise, time and practical financial insight behind the analysis. Their work has made this new view of SME financial resilience possible.

The report sets out proposals to fund the cost of care, improve payment, trace workforce funding and build proportionate aggregate intelligence beyond the largest providers.

The aim is to sustain the care people need, the staff who deliver it and the communities around them. That requires an evidence base which recognises improvement where it occurs, identifies vulnerability where it remains and supports decisions before financial pressure becomes lost capacity.

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EXECUTIVE SUMMARY

Executive summary

England has no routine, public, sector-level picture of the financial resilience of independent SME care-home providers. CQC Market Oversight is designed for large or significant regional providers whose failure would be difficult to replace; CQC states explicitly that it does not monitor the financial sustainability of the adult social care sector as a whole. This leaves a material evidence gap around the smaller providers that make up much of the residential market. ^[7]

The headline finding

The nominal net cash held by the main cohort increased, but much more slowly than its estimated monthly wage bill. Mean cash cover fell from 2.90 months of estimated wages at the oldest reporting point to 2.62 months at the latest. The median fell from 1.33 months to 1.23 months. The typical provider therefore has little more than one estimated month of payroll in net cash, before food, energy, insurance, maintenance, tax, capital investment and financing costs are considered.

What was analysed

The final analysis consists of two distinct datasets. The main cohort comprises 2,299 company records with three relative reporting points. It supplies the observed balance-sheet, borrowing and employee measures. A separate P&L calibration cohort of 165 companies supplies wage-per-employee and turnover-per-employee assumptions. Those assumptions are applied to the larger cohort to estimate monthly wages and annual turnover. Year 1 is the latest filed period for each company and Year 3 the oldest; the periods are not aligned to a common calendar year. ^[4]

The paper is England-only. Its local-economic discussion uses separately identified external evidence. Skills for Care reports that 84 percent of adult social care organisations had fewer than 50 employees in 2025/26; throughout this report, “approximately 80 percent” is used only as a rounded indication of the prevalence of smaller organisations. Neither that statistic nor the financial sample supports an extrapolation of national SME profits, jobs or economic value. ^[8]

These accounts do not reflect today’s full cost base

The latest accounts for 1,447 of the 2,299 main-cohort companies (62.9 percent) and 130 of the 165 calibration companies (78.8 percent) end before 6 April 2025. None of the calibration accounts covers the April 2026 SSP reform. This is not a full post-reform assessment. The outlook is a conditional judgement: without sufficient fee increases, prompt payment or offsetting improvements, later cost pressures are more likely to erode than restore cash resilience. ^[4]

Table 2. Core findings from the final analysis

Measure	Oldest point	Latest point	Change	Interpretation
Estimated monthly wage bill	£80,680	£98,668	+22.3%	Observed employee count multiplied by P&L-calibrated wage cost
Mean net cash	£204,873	£225,078	+9.9%	Cash less borrowing included in the model
Median net cash	£94,767	£110,361	+16.5%	Less affected by high-cash outliers
Mean net cash / wage bill	2.90 months	2.62 months	-9.6%	Mean relative cash headroom declined
Median net cash / wage bill	1.33 months	1.23 months	-8.0%	Typical provider has little more than one month of estimated wage cover
Current assets less cash — mean	£394,756	£523,493	+32.6%	Broad pool containing receivables, prepayments and other current assets
Collection proxy — mean	81.20 days	88.14 days	+6.93 days	Directional estimate; median rose from 27.75 to 30.70 days

Source: Care England analysis. Figures are rounded; Year 3 is the oldest relative point and Year 1 the latest.

What the findings mean

- The data does not show that providers hold less cash in nominal pounds. It shows that net cash failed to grow at the same rate as the estimated wage bill it must support. The deterioration is therefore one of relative headroom.
- In the 165-company calibration cohort, total wages rose by 22.9 percent and average turnover rose by 22.4 percent from the oldest to the latest reporting point. When the calibration assumptions are applied to the 2,299-company cohort, the estimated monthly wage bill rises by 22.3 percent and estimated annual turnover by 18.5 percent. These are operating assumptions, not a profit measure.
- Mean current assets other than cash increased by 32.6 percent. The modelled collection-cycle proxy rose from 81.20 to 88.14 days on the mean and from 27.75 to 30.70 days on the median. This is consistent with slower cash conversion, but the measure includes more than trade debtors and cannot attribute delay to local authorities, the NHS or private payers.
- The mean current ratio rose sharply from 3.39 to 6.17 while the median moved only from 1.46 to 1.49. The gap between mean and median is itself important: the sector is not financially uniform, and a limited number of unusually high values materially influence the average.
- An illustrative continuation of the observed direction shows that a further comparable slowdown in cash conversion could tie approximately £49,200 outside cash under the mean assumptions and £18,300 under the median assumptions. It does not forecast a date of failure. It demonstrates how further delay can reduce the already limited room available to absorb wages and other unavoidable costs.

What this paper does not claim

- It does not establish causation between commissioner payment behaviour and the increase in non-cash current assets.
- It does not measure audited trade-debtor days, because the numerator includes prepayments and other current assets.

- It does not provide a full profit-and-loss analysis for the 2,299-company core cohort; the 165-company calibration cohort is separate and used only to derive specified assumptions.
- It does not prove that all SMEs are on the same trajectory; the distribution is wide and outliers are important.
- It does not predict a precise date of market failure or claim that every provider will experience the same outcome.

The policy response

- 1 Fund the actual cost of care through a multi-year, ringfenced settlement linked to workforce and sector-specific inflation.
- 2 Require commissioners to provide a route for providers to invoice, or make an equivalent formal payment claim, for care delivered – including where a purchase order or placement agreement has expired while care continues – and pay valid, undisputed sums within 30 days.
- 3 Require every local authority and ICB to publish care-specific payment performance, aged debt and disputed-invoice data.
- 4 Introduce a nationally standardised annual fee-uplift timetable, with decisions and backdated payments completed before workforce cost increases take effect.
- 5 Create a statutory or grant-backed pass-through mechanism for Employment Rights Act and Fair Pay Agreement funding so that the full intended amount reaches providers promptly.
- 6 Expand financial oversight beyond the CQC Market Oversight cohort through a proportionate, anonymised SME resilience dashboard.
- 7 Develop an adult social care working-capital protocol covering purchase orders and placement agreements, invoicing and payment routes, invoice validation, continuing healthcare, deferred payment agreements, probate, responsibility disputes and retrospective fee adjustments.
- 8 Establish an emergency liquidity and market-stabilisation route for viable providers facing material public-sector payment delay.

SECTION ONE

Why this analysis is critical

Adult social care is delivered through a dispersed market of independent businesses, charities, voluntary organisations and statutory services. Skills for Care estimates 1.69 million total posts in England in 2025/26, including 1.59 million filled posts. This is whole-sector workforce context, not the number of people employed by the companies in this report.^[8]

That structure is a source of strength. It supports local knowledge, diversity, specialist provision, personal relationships and rapid adaptation. It is also a source of analytical weakness. Financial information is fragmented across Companies House filings, commissioner contract data, local intelligence and the private accounts of individual businesses. Small-company filing exemptions mean that turnover, operating costs and profit measures are often unavailable.

Why the evidence gap has persisted

Care England, the Care Association Alliance and the National Care Association's interpretation is that the evidence gap is partly economic. Reconstructing thousands of small-company accounts is labour-intensive and costly, while commercial analysis is commonly commissioned for particular transactions or portfolios. A national SME view may offer limited direct commercial return. That is an interpretation of the incentives, not a finding about the motives of individual advisers or government. The SMART Care Intel portal provides a sector-led way to develop the evidence alongside, rather than in place of, CQC Market Oversight.

The state has built a specific response to the risk of large-provider failure. CQC Market Oversight monitors providers that would be difficult to replace because of their scale or regional importance. It is designed to give local authorities advance warning if business failure is likely to interrupt care. It is not intended to assess the market as a whole, and CQC cannot prevent a provider from failing.^[7]

The missing middle

There is no equivalent national mechanism that shows whether a large number of smaller care-home businesses are becoming less resilient at the same time. A single SME closure may be locally manageable. A broad deterioration across hundreds or thousands of services is a system risk that can remain invisible until capacity, quality or investment has already been lost.

This report is therefore not a substitute for CQC Market Oversight. It is an attempt to complement it. The analysis asks a different question: what do the publicly available accounts of smaller, independent care-home companies reveal about cash resilience, short-term working capital and the ability to meet the most immediate obligation in a care business, the monthly wage bill?

A first, not a final, answer

This report offers a new large-scale view of the relationship between estimated wage obligations, net cash and non-cash current assets in this defined cohort. It does not claim that no previous research has examined SME care-home finance, nor that the cohort is a statistically representative sample of every small provider in England.

The value of the work lies in opening a new evidence base. The limitations are not reasons to disregard the signal. They are reasons to build a more consistent national dataset and to ensure that future policy decisions are not made solely from information about the largest corporate groups.

SECTION TWO

SMEs: care, communities and local economies

Skills for Care estimates that 84 percent of adult social care organisations had fewer than 50 employees in 2025/26. The joint publishers therefore use approximately 80 percent as a rounded indication of the prevalence of smaller organisations, not as a statutory SME count or a measure of beds, turnover or employment. The category includes single-home owner-operators, family businesses, small groups, charities and community organisations. The accounts cohort used here is narrower and is not a test of every statutory SME size criterion. ^[8]

This is an England-only analysis of company records associated with independent care homes. It does not cover the financial position of homecare, supported living or all working-age adult provision. Company records should not automatically be counted as individual care homes: a legal entity, registered provider and registered location are different units. Scottish and Welsh data was not reviewed and is currently outside the findings.

Why smaller providers may be more exposed

- They typically have fewer sources of revenue and less geographic diversification.
- A single delayed payment, empty bed, major repair or staffing issue can have a material effect on monthly cash.
- They may have less access to revolving credit, bond markets, group treasury functions or specialist credit-control teams.
- They may operate older estates requiring continuing maintenance and capital investment.
- Providers with a high proportion of local-authority or NHS-funded placements may have limited ability to change their funding mix; the workbook does not identify each company's payer mix.
- Management capacity is frequently concentrated in a small leadership team, making administrative friction disproportionately costly.

These characteristics do not mean every SME is fragile. Many are well run, asset-backed and deeply rooted in their communities. The point is that the same financial shock can have a different consequence depending on scale, diversification and access to capital. A delay that is inconvenient for a national group can become an immediate payroll problem for a single-home provider.

Ownership form does not remove financial risk

SME describes scale, not ownership. Charitable and not-for-profit providers may draw on donations, legacies or reserves and reinvest surpluses in their mission. They nevertheless face workforce, service and capital costs. The joint publishers' argument is that ownership form alone does not resolve an inadequate fee or a delayed payment; reserves are a finite source of support, not recurring income.

The Royal Masonic Benevolent Institution Care Company provides a recent contextual example. In February 2026 the charity announced that it would sell its portfolio of 15 care homes across England and Wales and exit residential care operations. It is included here as an ownership-neutral example of sustainability and investment decisions; it is not evidence from the England-only financial cohort. The announcement did not describe the charity as insolvent, and this report does not do so. ^[9]

A related example sits outside this report's residential cohort. Friends of the Elderly disclosed that it sold its remaining homecare services to a private operator after exiting local-authority contracts that had become unprofitable because of low fees and what it described as unsustainable public-authority contracting and payment practices. The example is included because it shows the same ownership-neutral mechanism in another regulated care service, not because it forms part of the analysis.^[10]

The policy conclusion is therefore ownership-neutral. Public, charitable, voluntary and commercial models can each contribute value, but no ownership form can compensate indefinitely for fees below cost, delayed income or inadequate funding for nationally mandated workforce changes.

The wider market is already capacity-constrained

Care-home occupancy reached 86.8 percent in the week ending 14 August 2026, according to DHSC provider statistics. CQC's 2024/25 reporting also identifies pressure on care-home capacity available to publicly funded residents. The joint publishers' concern is that loss of local capacity can reduce choice, complicate hospital discharge and require placements further from a person's community.^[11, 12]

2.1 The contribution behind the balance sheet

Skills for Care estimates that adult social care in England contributed £81.8 billion in Gross Value Added to the economy in 2025/26. That is a whole-sector estimate, not an SME care-home total, and it must not be multiplied by the approximately 80 percent small-organisation statistic: organisations vary greatly in size and activity. The relevance here is that care is both a service to people and an economic activity supported by employment and supply chains.^[8]

Smaller providers contribute through care roles, management, domestic services, catering and maintenance. Wages support household expenditure; procurement supports other businesses where supplies and services are purchased locally. These are economic mechanisms, not measured local multipliers from this workbook. The accounts do not disclose where staff live, what proportion of spending remains in the local economy or how much activity would be displaced following a closure.

The community contribution is also relational. Continuity of staff, family access and links with local professionals can be important to a resident's experience. Care England's Power of Care work sets out this wider infrastructure argument. In this paper, the financial results are used to consider what may be at risk, not to assign a monetary value to wellbeing or claim a causal effect on deaths, hospital use or employment.^[13]

2.2 Rural provision, choice and replacement

A small service can matter disproportionately where alternative provision is distant or offers a different type of support. In those circumstances a closure or restriction on admissions may mean longer journeys for relatives, loss of familiar relationships or a placement further from home. This is a place-based risk to examine through local market intelligence, not a quantified finding about rural companies in this cohort.

Commissioners' market-shaping decisions should therefore consider the availability and suitability of alternatives, local workforce capacity and the investment needed to sustain services. The Care Act's market-shaping framework includes provider diversity, quality and sustainability. Assessing those features requires more than a count of beds or the lowest available fee.^[14]

The joint organisations propose that local market-sustainability assessments record employment, local purchasing where known, specialist capacity and the consequences of potential exits alongside financial risk. A takeover may preserve jobs and care, and spending can move to another local provider; a business sale

must not automatically be described as a net economic loss. Future research should test these outcomes rather than assume them.

SECTION THREE

Data and methodology

Care England, David Woodward and Michael Butcher developed the core analysis from filed company accounts brought together through the SMART Care Intel financial dataset. External evidence is separately cited. The local-economic discussion and conditional outlook do not add observed financial fields to that dataset. ^[1, 4]

3.1 Two cohorts and three reporting points

Table 3. Cohort structure reviewed

Cohort feature	Count	Comment
WITHOUT P&L included companies	2,299	Main balance-sheet and employee cohort; all company numbers are unique
WITH P&L calibration companies	165	Separate cohort used to derive wage and turnover assumptions
Reporting points per company	3	Year 1 latest, Year 2 middle, Year 3 oldest
Maximum core company-period positions	6,897	Relative reporting points; not aligned to one national accounting date
WITHOUT P&L exclusions	195	Excluded from the final main cohort
WITH P&L exclusions	3	Excluded from the final calibration cohort

3.2 The calibration logic: WITHP&L informs WITHOUTP&L

WITH P&L contains 165 separate companies with enough information to calculate wage and turnover benchmarks per employee. WITHOUT P&L contains the 2,299 companies in the main analysis. Year-specific benchmarks from the smaller cohort are applied to employee counts in the larger cohort. The calibration cohort is not a linked subset of those 2,299 companies. Availability of fuller accounts may be associated with size, group structure or reporting practice, so the calibration is not a random or independently validated representation of all SMEs.

Table 4. Observed and modelled measures

Measure	Status	Methodological note
Cash and borrowing	Observed from filed balance-sheet data	Used to calculate the report's simplified net-cash measure
Employee count	Observed filing field	Used as a comparable workforce measure; it may not be a consistently defined FTE measure
Average annual wage per employee	Calculated in WITH P&L	£24,842 in Year 3; £26,735 in Year 2; £28,691 in Year 1
Estimated monthly wage bill	Modelled in WITHOUT P&L	Employee count multiplied by the P&L-calibrated wage value, divided by 12
Turnover per employee	Calculated in WITH P&L	£47,342 in Year 3; £51,080 in Year 2; £52,996 in Year 1

Measure	Status	Methodological note
Estimated annual turnover	Modelled in WITHOUT P&L	Turnover per employee multiplied by employee count
Current assets less cash	Calculated broad proxy pool	Includes receivables, prepayments and other current assets
Collection-cycle proxy	Modelled	$(\text{Current assets less cash}) \div \text{estimated turnover} \times 365$

3.3 Core definitions

Net cash. Cash reported on the balance sheet less bank loans and overdrafts included in the model. It is a simplified measure of immediately visible cash headroom and does not represent a full treasury or liquidity assessment.

Net current assets. Total current assets less total current liabilities. Positive net current assets indicate that short-term assets exceed short-term liabilities; negative net current assets indicate a short-term funding deficit.

Current ratio. Total current assets divided by total current liabilities. A higher ratio can reflect greater liquidity, but it can also reflect cash being replaced by receivables or other less immediately available current assets. It must be interpreted alongside the composition of those assets.

Cash cover of wages. Net cash divided by the estimated monthly wage bill. It shows how many months of estimated payroll the reported net cash could cover if no further income were received. It is not a measure of how long the entire business could operate, because care homes also have food, utilities, rent, maintenance, insurance, tax and other costs.

Working-capital collection proxy. Total current assets less cash divided by estimated annual turnover, multiplied by 365. It includes items other than trade debtors and is not an audited collection period. With the same turnover denominator, adding non-debtor assets makes it broader than a trade-debtor measure; estimated turnover and differences in asset composition mean it is not a guaranteed upper bound on actual debtor days.

3.4 Exclusions and outlier treatment

The final analysis excludes 195 main-cohort records and 3 calibration records. The analytical discussion identifies large employee-number changes, including movements above 25 percent, and insufficient usable cash or borrowing information as reasons for exclusion as inclusion would skew the analysis. These criteria were intended to improve comparability. The analysis does not provide a complete reason-coded schedule for every excluded company; no exact allocation of the 198 exclusions between reasons is claimed.^[4]

The final analysis contains no duplicate company number in the 2,299 included records and no overlap between the included and excluded main cohorts.

The sample is constrained by availability and comparability of filed accounts. It may under-represent recently established, restructured or exited providers and those with incomplete records. These are selection limitations, not evidence that the excluded companies were stronger or weaker. No population confidence interval or percentage of all providers at risk is estimated.

3.5 Mean, median and outliers

Means and medians are reported because the distribution is skewed. High values can materially influence the mean; the median identifies the middle observation for each measure. They do not describe one composite “average care home”, and a gap between them does not by itself measure the number of distressed providers. Cash-cover means and medians are calculated from company-level ratios, not by dividing the summary cash and wage figures.

3.6 What the reporting dates can and cannot capture

Year 1 is each company’s latest reporting point, not one common financial year. Latest year ends range from 31 May 2024 to 30 April 2026 in the main cohort and from 30 April 2024 to 28 February 2026 in the calibration cohort. Of the main cohort, 1,447 of 2,299 records (62.9 percent) end before 6 April 2025; the equivalent figure is 130 of 165 (78.8 percent) in the calibration cohort. Only 2 main-cohort records, and no calibration records, end on or after 6 April 2026.^[4]

These date counts do not measure the fraction of extra cost captured. Accounts ending after a policy change may cover only part of its first year, and employer circumstances differ. The April 2025 National Insurance changes are therefore incompletely reflected. Because all wage-calibration accounts end before April 2026, the estimated wage measures do not incorporate a post-reform SSP period. Further 2027 employment reforms and the intended April 2028 Fair Pay Agreement are outside the observed periods.^[17, 23, 24, 6]

The current results should be treated as a historical baseline, not evidence that providers have absorbed the subsequent cost changes. Future releases should report their actual year-end coverage and test how the additional pressures appear as newer accounts become available. The next extraction will not necessarily capture every later reform.

SECTION FOUR

What the data shows

The analysis tells a consistent liquidity story. Estimated wages rose quickly. Observed net cash increased, but not at the same pace. More value accumulated in current assets other than cash, and the modelled collection cycle lengthened. The result is less relative cash headroom even though some conventional balance-sheet ratios appear to improve. The word “estimated” is retained for wage and turnover measures because they are modelled from the calibration cohort; cash and balance-sheet values are observed from filed accounts.

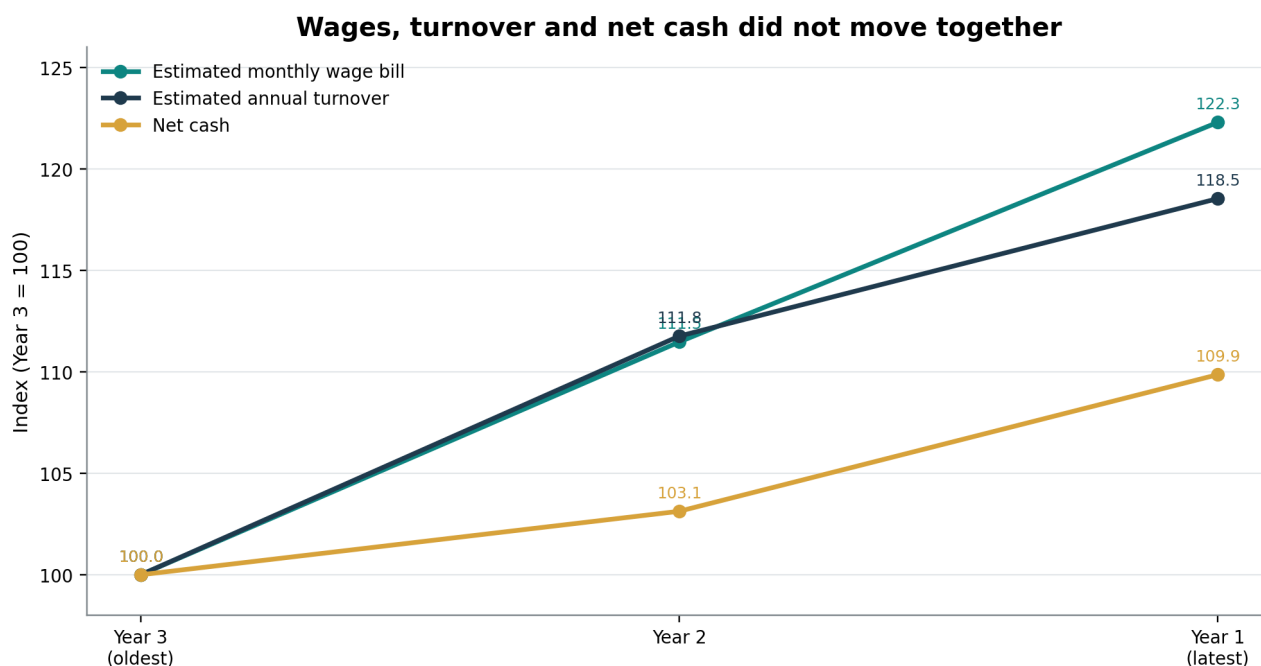
4.1 The estimated monthly wage bill rose by 22.3 percent

The mean estimated monthly wage bill increased from £80,680 at the oldest reporting point to £98,668 at the latest, a rise of £17,989 or 22.3 percent. The median increased from £72,456 to £86,073, or 18.8 percent. In the separate P&L calibration cohort, total wages rose by 22.9 percent and average annual wage cost per employee rose from £24,842 to £28,691.^[4]

Average employee numbers also rose modestly. The data cannot determine whether this reflects vacancy filling, reduced agency dependence, changes in dependency, service growth or another factor. The liquidity point is narrower: the monthly cash obligation to the workforce increased materially and must be met before the provider can defer or rearrange many other costs.

4.2 Net cash rose, but far more slowly than wages

Mean net cash increased from £204,873 to £225,078, or 9.9 percent. Median net cash increased from £94,767 to £110,361, or 16.5 percent. It would therefore be inaccurate to state that cash fell in nominal terms across the cohort. The deterioration appears when net cash is compared with the estimated wage obligation it must support.



Wages, turnover and net cash did not move together (index, oldest year = 100).

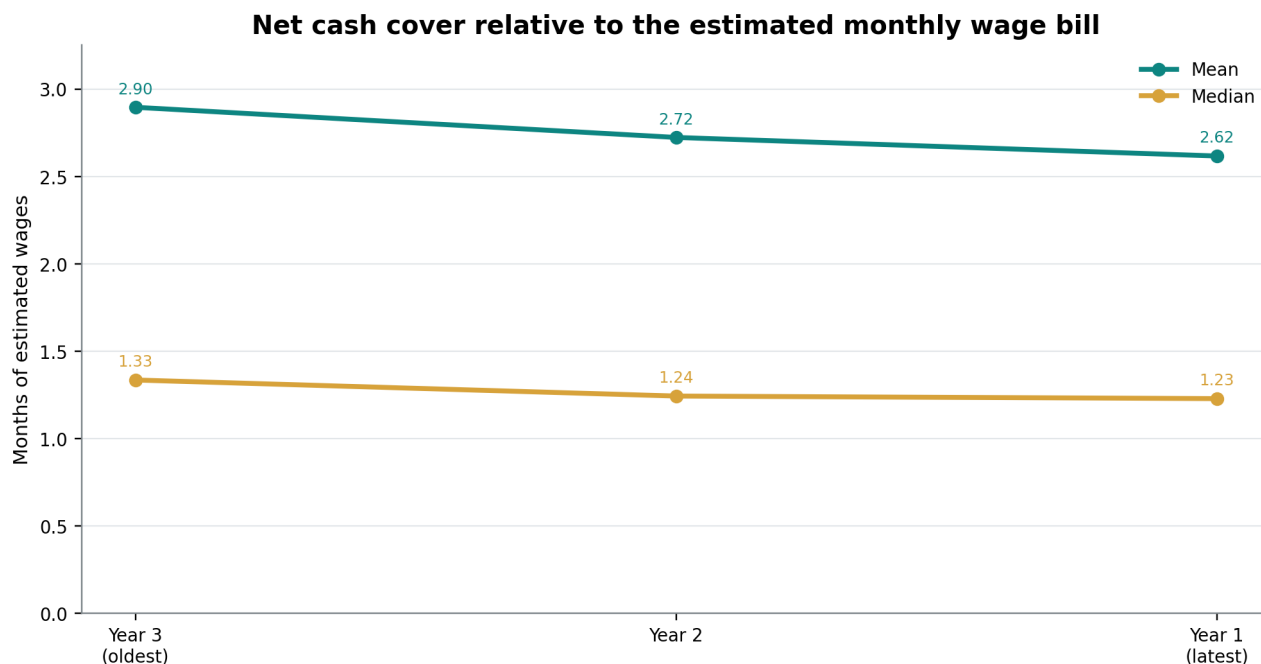
Figure 1. Indexed movement in estimated wage bill, estimated turnover and net cash

Source: Care England analysis. Oldest reporting point indexed to 100.

Estimated annual turnover in the main-cohort model increased by 18.5 percent, from approximately £1.845 million to £2.187 million, while the estimated monthly wage bill increased by 22.3 percent. On this basis, wages rose from about 52.5 percent to 54.1 percent of estimated turnover. In the separate calibration cohort, average turnover increased by 22.4 percent while total wages increased by 22.9 percent, again indicating slight wage-share pressure before non-pay inflation is considered.

4.3 Cash cover fell at both mean and median

Mean net-cash cover fell from 2.90 months of the estimated wage bill to 2.62 months, a decline of 9.6 percent. Median cover fell from 1.33 months to 1.23 months, a decline of 8.0 percent. The median is the more immediate warning: the middle provider has net cash equivalent to only a little more than one estimated month of payroll, and that cash must also support tax, food, utilities, insurance, maintenance and other obligations.



Net cash cover relative to the estimated monthly wage bill (months).

Figure 2. Net cash expressed as months of the estimated wage bill

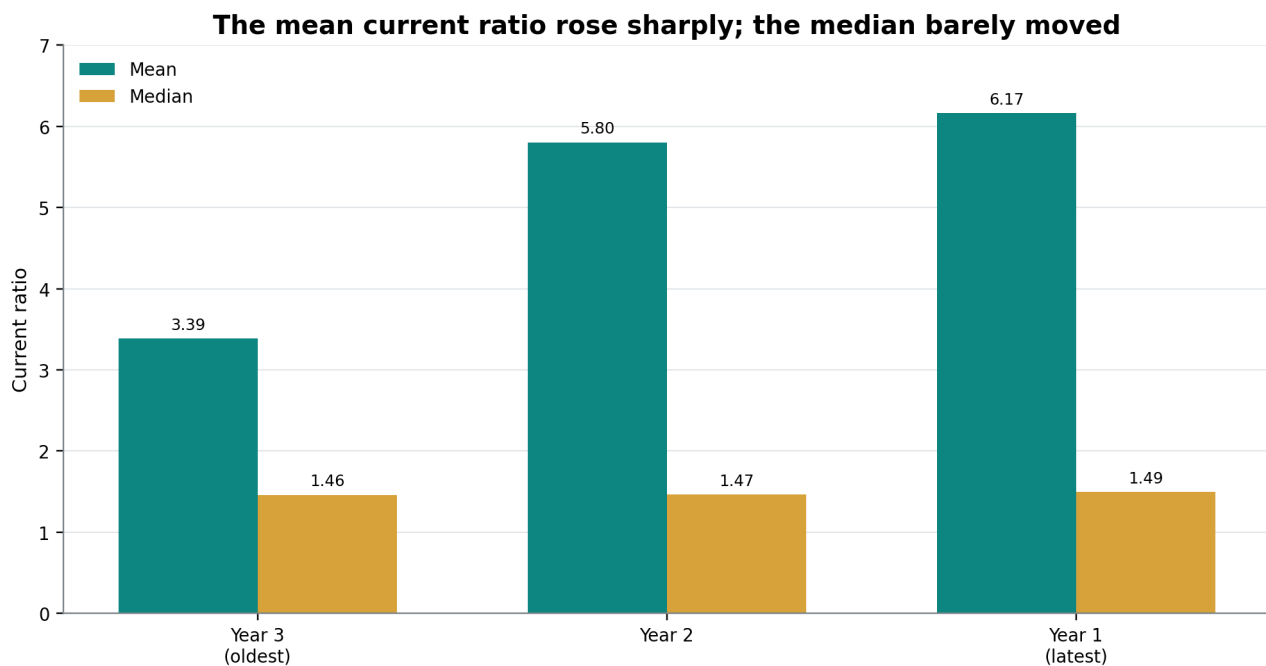
Source: Care England analysis. Net cash is cash less borrowing included in the model.

Why payroll is the right stress point

Care providers have many costs, but wages and payments to HMRC are the two obligations that cannot be deferred without immediate consequences. A fall in cash cover does not mean a provider is insolvent; it means there is less time to resolve a delayed payment or unexpected cost before payroll becomes exposed.

4.4 The current ratio improved—but the typical provider barely moved

The mean current ratio increased from 3.39 to 6.17. Read alone, that could appear to show a substantial improvement in short-term financial strength. The median, however, moved only from 1.46 to 1.49. The divergence shows that the mean is being pulled upward by a limited number of entities with unusually high current assets relative to current liabilities.



The mean current ratio rose sharply; the median barely moved.

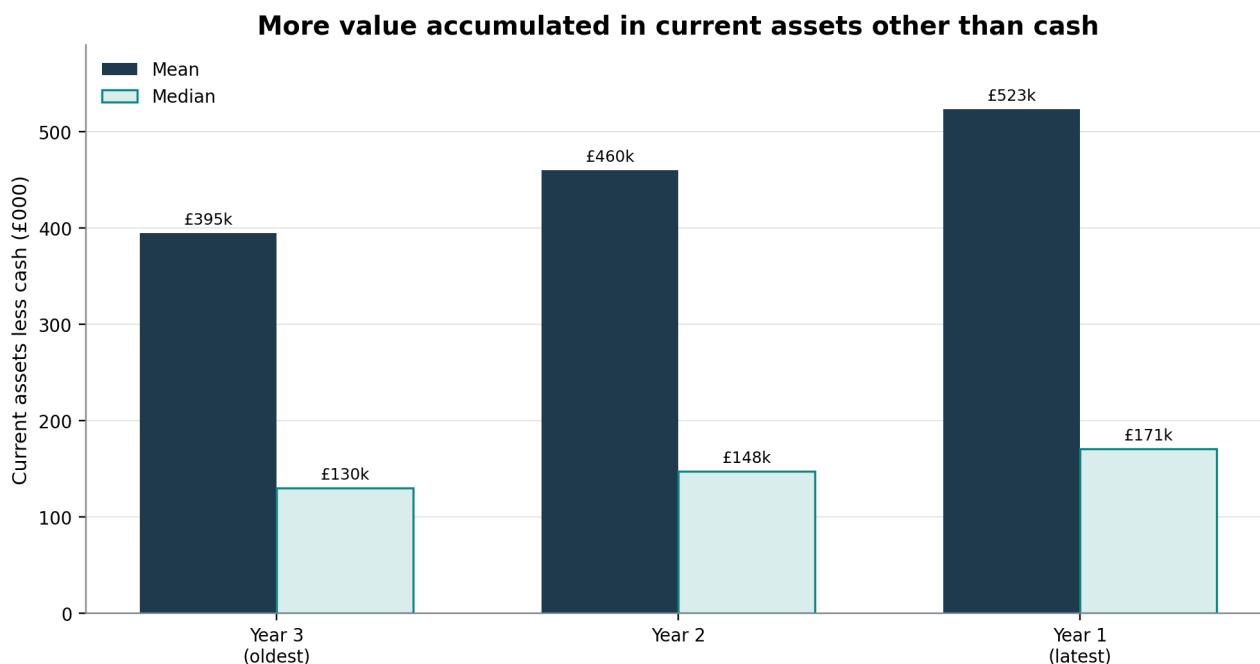
Figure 3. Mean and median current ratio across the three reporting points

Source: Care England analysis. The Year 2 mean is 5.80 and the median 1.47.

A current ratio depends on both the level and composition of current assets and on current liabilities. Receivables and prepayments cannot necessarily be used immediately to pay staff. Higher non-cash assets or lower current liabilities can therefore raise the ratio without a matching improvement in accessible cash. The mean–median divergence indicates variation, but does not establish which mechanism applies to every company.

4.5 Current assets other than cash increased by 32.6 percent

Mean total current assets less cash increased from £394,756 to £523,493, a rise of £128,738 or 32.6 percent. The median increased from £129,902 to £170,892, or 31.6 percent. This pool is used as a proxy for amounts tied up outside cash. It will include trade debtors, but may also contain prepayments, accrued income, tax balances, stock and other receivables.



More value accumulated in current assets other than cash (£000).

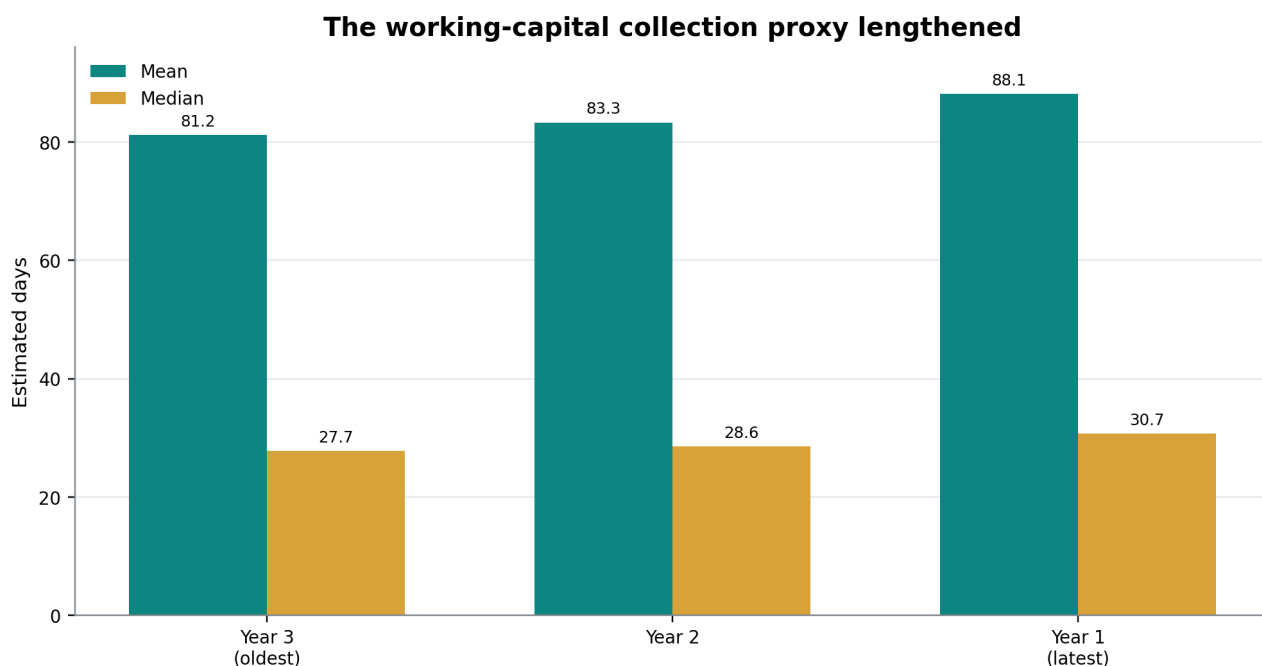
Figure 4. Mean total current assets less cash

Source: Care England analysis. The proxy pool includes more than trade debtors and is presented with that qualification.

The faster growth of non-cash current assets is consistent with slower cash conversion, but does not identify a payer or cause. Explanatory material suggests delayed new funding, transitions between private and public responsibility, probate and individual responsibility disputes as possible mechanisms. Changes in prepayments or other receivables are also possible. These are explanations to investigate, not causal findings from the accounts.

4.6 The working-capital collection proxy increased at both mean and median

The estimated collection proxy rose from 81.20 to 88.14 days on the mean: 6.93 days, or 8.5 percent. The median rose from 27.75 to 30.70 days: 2.95 days, or 10.6 percent. The movement in the median means the change is not confined to the mean alone; it does not show that every provider's collection time worsened, or establish how much was overdue trade debt.^[4]



The working-capital collection proxy lengthened (estimated days).

Figure 5. Mean and median working-capital collection proxy

Source: Care England analysis. Formula: (total current assets less cash) ÷ estimated annual turnover × 365. This is not audited trade-debtor days.

At the latest estimated mean turnover, 6.93 additional days correspond to approximately £41,500 using a 365-day year. This is a sensitivity calculation, not measured overdue debt. It is about one-third of the £128,738 increase in the broad non-cash asset pool, but that numerical comparison does not allocate the increase between causes. A mean of company ratios is not the ratio of the cohort's totals; the residual cannot simply be labelled revenue growth or underfunding.

4.7 Net current assets increased, but cash did not keep pace

The net-current-assets-to-wage ratio increased on the mean from 2.54 to 2.95 and on the median from 1.16 to 1.24. Short-term asset cover has therefore not collapsed. The issue is composition: a greater share of that cover appears to sit outside immediately available cash.

This distinction explains why a business can look stronger on a conventional balance-sheet ratio while feeling more constrained in practice. Accounts measure rights to receive money and obligations to pay it. Payroll requires the first to convert into cash before the second falls due.

SECTION FIVE

Why income on paper is not cash in the bank

A provider can deliver more care, record higher income and still have less cash available when bills fall due. Income is recorded when it is earned; cash flow records when money actually enters or leaves the bank account.

A care home can recognise an agreed fee uplift, deliver the care and record the income, yet wait weeks or months for the associated cash. It may also record accrued income while a retrospective local-authority or NHS uplift is calculated, or hold a receivable while an invoice is validated. Recording the income does not make it available for payroll.

The working-capital chain

1. The provider delivers care every day and incurs wages continuously.
2. The provider invoices a local authority, ICB, family, estate or individual according to different contractual processes.
3. Income is recognised, but validation, reconciliation, assessment, dispute or administrative delay may postpone cash.
4. The provider pays staff, tax, food, energy and suppliers before all income has been received.
5. The gap is financed from cash reserves, overdrafts, shareholder funds or delayed investment.

A provider's ability to continue delivering care depends on receiving sufficient cash, at the right time, to meet obligations that cannot wait. Income recorded in the accounts cannot be used to pay staff until it reaches the bank.

What this dataset can establish

The main cohort provides balance-sheet and employee information, not a full set of operating costs. The separate 165-company calibration cohort supplies wage and turnover assumptions. Together they support an analysis of relative cash headroom; they do not establish an average net profit for the main cohort.

Calibration boundary

The WITH P&L cohort contains 165 companies, with 3 exclusions. It is used only to derive the specified wage and turnover assumptions. It is not a linked subset of the main cohort, and the workbook does not provide a consistently reconciled full operating account for those 2,299 companies.

The central conclusion is therefore about cash resilience: estimated wage obligations have risen faster than reported net cash, and the broad working-capital collection measure has lengthened. These findings identify narrowing room to absorb costs or payment delays without assigning a cause to every company.

SECTION SIX

The view from CQC Market Oversight

CQC Market Oversight is a complementary source of national financial intelligence, but it covers a different population and serves a different statutory purpose. It monitors providers whose failure would be difficult to replace, using detailed submissions, forecasts and engagement. CQC states that it does not monitor the financial sustainability of the sector as a whole and cannot intervene to prevent failure.^[7]

What CQC's more recent reporting adds

CQC's 2023/24 State of Care report recorded an EBITDARM operating indicator of 26.9 percent for older people's care-home providers in March 2024, compared with 22.5 percent in March 2022. This is a dated observation for the Market Oversight care-home population, not a measure calculated for this SME cohort.^[15]

The newer 2024/25 State of Care report, published on 24 October 2025, reported an EBITDARM indicator of 16.2 percent for homecare providers in March 2025, nearly one percentage point lower than a year earlier. This concerns homecare, not care homes: it must not be presented as a fall from 26.9 percent or a later observation in the same series.^[12]

For older people's care homes, the newer report highlights pressure on publicly funded capacity and reliance on international recruitment to reduce vacancies and agency use. These findings reinforce the need to consider workforce, funding and capacity together, rather than infer current cash resilience from one operating indicator.^[12]

Table 5. Complementary but different evidence bases

Dimension	CQC Market Oversight	Care England SME analysis
Purpose	Early warning of likely failure affecting continuity of care	Understand broad resilience and direction across independent SMEs
Coverage	Large or difficult-to-replace providers meeting statutory entry criteria	2,299-company main cohort plus a separate 165-company calibration cohort
Information	Detailed financial submissions, forecasts and engagement	Filed accounts plus clearly identified P&L-derived assumptions
Main strengths	Timely, provider-specific, forward-looking	Large cohort; public-account reproducibility; view of dispersed market
Main limitations	Not the whole sector; data largely unpublished at provider level	Lagged accounts; separate calibration cohort; modelled turnover and wages; no payer split

The policy gap

The two evidence bases answer different questions. CQC's scheme provides detailed intelligence on difficult-to-replace providers; this study examines cash headroom across a defined cohort of smaller companies using lagged accounts. Neither substitutes for the other, and no conversion of CQC's operating indicators into an SME cash-cover figure is made.

A complete national view therefore requires both lenses: detailed monitoring of providers whose individual failure would be difficult to replace, and aggregate monitoring of the many smaller providers whose collective deterioration would be equally difficult to replace.

SECTION SEVEN

The wider fiscal backdrop

The company accounts do not identify the cause of the cash-conversion change. External evidence is therefore used here to establish plausible system conditions, not to convert correlation into causation. Four factors are particularly relevant: structural underfunding, local-authority financial pressure, NHS financial control, and payment administration.

7.1 The cost of care is not fully funded

Care England's Priced to Fail analysis estimated that the gap between local-authority fees and the cost of older people's residential and nursing care reached £2.36 billion in 2025/26, up from £1.59 billion in 2022/23. It estimated annual shortfalls of more than £10,000 for an average residential placement and more than £23,000 for nursing care. The gap is structural: it is a mismatch between the rate paid and the costs providers are required to meet.^[2]

DHSC's 2025/26 fee reporting showed weighted average uplifts of 5.3 percent for older people's residential care and 4.9 percent for nursing care. Priced to Fail models total delivery-cost increases of approximately 7.8–8.1 percent for that year; its approximately 10.6 percent employment-cost figure concerns the work-force component, not all expenditure. These different measures should not be treated as interchangeable. The companion analysis indicates that fee growth did not match the modelled cost increase, although individual providers' positions vary.^[16, 2]

The filed-account lag makes this point especially important. Section 3.6 shows that most latest accounts end before the changes to employer National Insurance on 6 April 2025, when the rate rose from 13.8 to 15 percent and the secondary threshold fell from £9,100 to £5,000. Other accounts reflect differing amounts of the post-change period. The increase in Employment Allowance also means the net effect varies between eligible employers. This study is not a full assessment of the policy's effect.^[17]

The Priced to Fail model already includes the April 2025 National Insurance change in its 2025/26 work-force-cost assumptions. It should not be added again to the £2.36 billion estimate. The distinction is that the companion report models that cost pressure, whereas the SME accounts largely predate it or capture it only partially.^[2]

The Hidden Subsidy examines local-authority-arranged full cost clients: people paying for their own care whose placements are priced through an authority. Its separate scenario analysis estimates an annual provider-revenue differential of approximately £371 million to £506 million compared with prevailing private rates. This is a fee-comparison estimate, not an audited loss or an amount measured in the SME accounts; it should not be added to the Priced to Fail gap without checking overlap.^[3]

Non-pay pressures also require attention. ONS's August 2026 release records continued food-price inflation and higher motor-fuel prices. These household-price indicators provide context, not a care-home cost index; commercial energy contracts, insurance, maintenance and purchasing arrangements differ. Where rising input costs are not met by additional income or savings, the funding gap and demand on cash increase.^[18]

7.2 Local authorities are financially constrained

ADASS reported that councils overspent adult social care budgets by £715 million in 2025/26 as need and complexity increased. The National Audit Office has separately concluded that local-government funding has not kept pace with demand, complexity and the cost of delivery.^[5, 19]

Local authorities are the principal public commissioners of adult social care and have statutory market-shaping responsibilities. Care Act guidance requires them to consider the impact of commissioning on sustainability and not to set fee levels that threaten the long-term availability of appropriate quality provision.^[14]

The pressure on councils is real. It does not remove the consequence of inadequate fees or delayed payments; it explains why those risks may be transferred. A sustainable answer must fund councils properly while also creating accountability for the amount and timing of money that reaches providers.

7.3 NHS commissioners are also under financial control

NHS England reported that 2025/26 system plans would show an aggregate £2.2 billion deficit without revenue support. With £2.2 billion of revenue support, all systems planned an overall balanced position. This is 2025/26 financial-planning context, not a 2024/25 outturn or a measure of debt owed to care providers. The SME accounts do not identify NHS receivables or establish that a particular financial-control policy caused payment delay.^[20]

The analysis cannot isolate NHS debt. Care England is separately working with providers, NHS England and DHSC on documented continuing-healthcare payment problems. Those cases are not used to quantify this report and are referenced only as contextual evidence that material arrears and processing backlogs exist at scale.

Evidence boundary

Care England holds provider case evidence relating to local-authority and NHS payment delay, including continuing-healthcare arrears. No individual provider or commissioner is named and no case value is used in the quantitative findings because the evidence has not been assembled as a publication study sample. The report recommends that this gap is addressed through national payment reporting and future payer-level research.

7.4 Payment administration can convert funding pressure into provider debt

Payment delay is not always a refusal to pay. It can arise from retrospective fee decisions, incorrect or expired purchase orders or individual placement agreements, disputed dates, mismatched care records, invoice controls, delayed financial assessments, continuing-healthcare eligibility, changes in responsibility, deferred payment arrangements, probate or system migrations. In some local-authority and NHS arrangements, payment is controlled through a commissioner purchase order, placement agreement or payment schedule rather than a provider-submitted invoice. Where an authorisation expires but care continues, the provider may therefore continue incurring wages and other costs while the formal route to payment is unresolved. The cause is important operationally, but the cash effect on the provider is the same until the issue is resolved.

For contracts within scope, the Procurement Act 2023 requires contracting authorities to accept and process qualifying electronic invoices and implies payment terms requiring valid, undisputed invoices to be paid within 30 days, with notification without undue delay where an invoice is invalid or disputed. The Act does not prevent an authority from operating a particular invoicing system, but qualifying suppliers retain a route to submit an electronic invoice for processing. Legacy contracts and separately regulated arrange-

ments require their own legal and contractual checks. The report therefore proposes a care-wide standard that preserves a clear invoice or equivalent formal payment route for care already delivered, including while a purchase order, individual placement agreement or other authorisation is being renewed or disputed.^[21, 22]

The opportunity

Government now has statutory transparency and invoicing mechanisms that can be applied to care commissioning. The missing step is to ensure providers always have a clear route to invoice, or make an equivalent formal payment claim, for care delivered – including where a purchase order or individual placement agreement has expired while care continues – and then make care-specific performance visible: valid claims paid within 30 days, disputed items resolved within a defined period, aged debt by service type, and retrospective fee uplifts paid by a national deadline.

7.5 Workforce reforms increase the need for reliable pass-through

From 6 April 2026, Statutory Sick Pay became payable from the first full day of sickness absence and the lower earnings limit was removed. The cost is borne by employers and is not recoverable from HMRC. These protections strengthen workers' rights, but the study's wage-calibration accounts all end before the reform and do not capture a post-reform period.^[23]

For clarity, the SSP obligation is borne by employers; this paper does not suggest it is recoverable from HMRC. The funding recommendation concerns whether commissioner fees reflect the additional cost of providing care, not reimbursement of individual sick-pay claims.

Employment Rights Act changes are being phased in, not introduced on one date. The government's timetable, updated on 25 September 2026, identifies further measures for 2027, including changes to dismissal protections and rights relating to guaranteed hours and short-notice work. The detailed timing and effects vary by provision. None of these 2027 changes is measured in the accounts used here.^[24]

The government's July 2026 consultation response sets out negotiations beginning around April 2027 and a first Fair Pay Agreement coming into effect in April 2028. Government has identified a £500 million envelope for the first agreement. These are implementation plans and funding parameters, not a calculation of each provider's costs; the eventual agreement and payment mechanism must be assessed separately.^[6, 26]

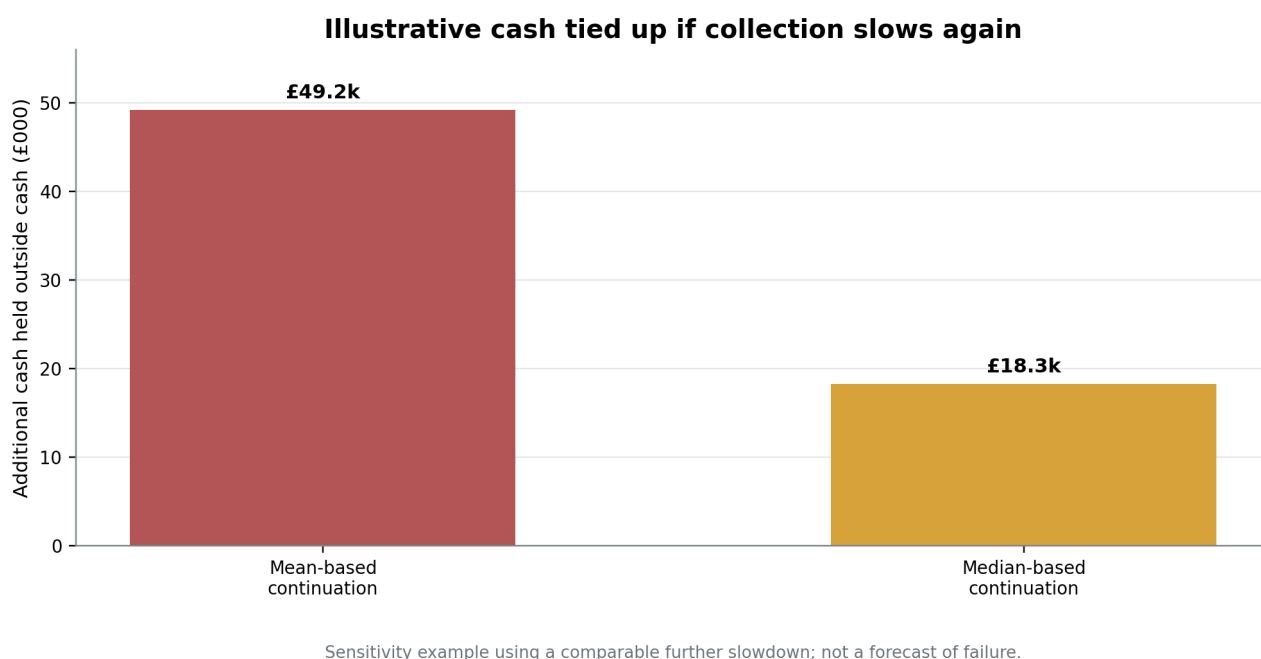
A provider with limited cash cover is exposed if a new employment liability precedes a corresponding fee uplift. Full, timely funding can mitigate that incremental cost risk; it does not remove pre-existing shortfalls or other operating pressures. The joint organisations propose a transparent trail from national allocation to commissioner fee and provider receipt, covering both local-authority and NHS commissioning routes.

SECTION EIGHT

The trajectory

The final analysis supports a sensitivity illustration rather than a forecast. It applies a further deterioration equal to the change already observed between the oldest and latest relative reporting points: 6.93 days on the mean and 2.95 days on the median. Applied to the next-period turnover assumptions, that would leave approximately £49,200 more outside cash under the mean analysis and £18,300 under the median analysis. The illustration represents a comparable future reporting interval, not a stated number of calendar years. ^[4]

Median net cash is already 1.23 times the estimated monthly wage bill. On the observed historical measures, wages have risen faster than cash, relative cover has declined and the broad collection proxy has lengthened. If similar changes continued without offsetting income, efficiency, capital or financing responses, providers exposed to them would have less capacity to absorb disruption. The model does not count how many would fail.



Illustrative cash tied up if collection slows again (sensitivity example, not a forecast).

Figure 6. Illustrative cash tied outside the bank if the collection proxy slows again

Source: Care England sensitivity analysis using the SME Care Home Financial Resilience Analytical Dataset. The bars are additional working-capital requirements under stated assumptions, not forecast cash balances or measured arrears.

How to interpret the scenario

- It shows sensitivity: a further change similar to the one already observed would withhold material cash from wages, tax, suppliers and investment.
- It does not demonstrate that every provider will reach the same position or that failure will occur within a fixed period.

- It excludes food, energy, insurance and maintenance inflation; corporation tax; capital investment; interest and financing costs; and exceptional expenditure. These can place further demands on cash, but their future amounts are not measured here.
- It does not model differences between providers, including payer mix, occupancy, service type, costs, borrowing, estate condition and reserves. Those differences can make an individual outcome better or worse than the example.
- It excludes additional Employment Rights Act and Fair Pay Agreement costs. Where the full additional cost is not funded and passed through promptly, it would add pressure. Adequate timely funding can mitigate that incremental risk.

The direction of the observed cash-resilience measures is adverse, but no failure date or number of failures is predicted. Further payment or cost pressure could narrow headroom and restrict investment or admissions before insolvency. The illustration does not model a complete profit-and-loss or cash-flow account. Omitted cash demands may worsen outcomes, while provider differences and offsetting responses can work in either direction.

A deteriorating trajectory is not necessarily visible as failure

Financial pressure can appear as changed behaviour before insolvency. Possible responses include deferring refurbishment, postponing technology or energy-efficiency investment, restricting expansion, seeking a different funding mix or considering sale. These are risks and responses to investigate, not behaviours measured for the companies in the workbook.

Stabilisation should not be confused with restored resilience. Improving occupancy or recruitment can co-exist with inadequate fees, delayed investment or limited cash cover. Given the incomplete coverage of later workforce costs and the funding mismatch identified in the companion reports, the joint publishers consider a broad recovery in cash resilience unlikely without sufficient fee increases, prompt payment or offsetting improvements. This is an assessment of risk, not a result measured in the current accounts.

Subsequent releases are therefore expected to reveal more of these cost pressures as the relevant accounts become available. Further erosion is a reasonable conditional expectation, but neither its scale nor the result of the next extraction can be predetermined. Changes in occupancy, funding mix, efficiency, finance and the composition of the available cohort could alter the observed outcome.

SECTION NINE

Consequences of inaction

9.1 Workforce risk

Care delivery is labour-intensive. When cash cover narrows, payroll can become a central monthly risk. Providers may respond through recruitment, vacancy, overtime or management decisions, with potential consequences for continuity, supervision and training. The accounts do not measure those responses or prove a relationship with quality; the concern is the operational exposure created by limited headroom.

The workforce position has improved in some respects: Skills for Care reported a 6.2 percent vacancy rate in 2025/26, with approximately 96,000 vacant posts. The sector will nevertheless require substantial workforce growth by 2040. A financial model that weakens providers just as government seeks better pay and a larger domestic workforce is internally inconsistent.^[8]

9.2 Quality and safety risk

This analysis does not establish a causal relationship between financial pressure and CQC ratings. Reduced management time, deferred maintenance, constrained training, unstable staffing and limited capital investment are possible pathways to service risk, not outcomes measured in this workbook. CQC's reporting on workforce and capacity underlines the need to monitor those risks alongside financial resilience.^[12]

The correct policy response is not to lower quality expectations. It is to ensure that the financial model enables providers to meet them. Regulation cannot compensate for a commissioning system that prices below cost or pays too late.

9.3 Estate and investment risk

Care homes require continuous capital investment: roofs, heating, lifts, fire systems, kitchens, bathrooms, infection-prevention infrastructure, digital connectivity, decarbonisation, and adaptations for changing dependency. Cash absorbed by working capital is cash unavailable for those purposes. Over time, the sector risks an ageing estate in which investment is driven by immediate compliance rather than long-term improvement.

Reduced long-term liabilities can indicate a lack of refinancing or investment. The available figures do not support a firm conclusion. Tangible assets rose modestly and long-term liabilities fell modestly, a pattern that could reflect routine debt repayment, asset additions, revaluation or a mix. The stronger evidence is the opportunity cost: cash tied up outside the bank cannot be invested elsewhere.

9.4 Capacity, consolidation and local choice

SME owners and trustees can respond to sustained pressure by selling to a larger operator, entering a sale-and-leaseback structure, redeveloping the site for another use or closing. Consolidation is not inherently negative, and investment from a new owner can protect services. But consolidation driven by structural underfunding can reduce local diversity, increase landlord exposure and remove capacity that is difficult or expensive to recreate. The risk applies across commercial, charitable and voluntary ownership.

The Care Act requires authorities to promote a diverse, sustainable market. That duty is engaged before a provider formally fails. Market shaping should identify deteriorating liquidity, reduced investment and

declining willingness to accept placements as leading indicators of future insufficiency. Currently most commissioners do not have visibility of this data at a provider level.

9.5 NHS flow and public cost

Care-home capacity supports hospital discharge, step-down care, rehabilitation, nursing and end-of-life care. When capacity is lost or providers restrict publicly funded admissions, people wait longer in hospital or are placed further from home. The resulting NHS cost can exceed the funding that would have stabilised the care placement in the first place.

Late payment may also create avoidable financing and administrative costs. Where the statutory late-commercial-payment regime applies, interest is 8 percentage points above the Bank of England base rate. Contractual provisions and applicability must be checked: this is not a universal contractual rate. Prompt payment reduces the need for credit and debt-recovery work^[27]

SECTION TEN

Policy actions

The joint publishers propose a combined funding, commissioning, payment and oversight response. Better payment can release working capital but cannot by itself close a recurring cost gap. Higher fees that arrive late may still leave immediate cash pressure. The following are recommendations for consideration, not statements that each mechanism is already a legal requirement.

Table 6. Recommendations at a glance

No.	Recommendation	Lead responsibility	Action
1	Fund the actual cost of care	HM Treasury and DHSC	Provide an immediate correction for the existing funding gap and move to a multi-year settlement linked to sector-specific inflation, National Living Wage, employer on-costs and the cost of regulated quality. Funding should not depend principally on unequal local tax bases.
2	Ringfence and trace workforce funding	DHSC, MHCLG and commissioners	Every Employment Rights Act and Fair Pay Agreement funding envelope should include a transparent national allocation, commissioner pass-through duty, provider-level audit trail and timetable. Unspent or unpassed funding should be identifiable and recoverable.
3	Enable invoicing and apply a national 30-day care payment standard	Local authorities, ICBs and Cabinet Office	Require commissioners to provide a route for providers to submit an invoice or equivalent formal payment claim for care delivered, including where a purchase order or individual placement agreement has expired while care continues. Pay valid, undisputed sums within 30 days, with faster recurring payments where possible, and align implementation with the applicable legal regime and contract.
4	Resolve disputes quickly	Local authorities and ICBs	Notify providers without undue delay where an invoice is invalid or disputed. Establish a maximum 10-working-day validation period and a 20-working-day escalation route, while paying the undisputed amount.
5	Publish care-specific payment performance	DHSC, NHS England and contracting authorities	Publish adult-social-care payment performance: average days; percentage within 30 days; value over 30/60/90 days; disputed value; retrospective uplift arrears; CHC/FNC debt; deferred-payment debt; and responsibility disputes.
6	Set a national annual fee timetable	DHSC and local authorities	Require indicative fee assumptions before budget setting, final decisions before 1 April and payment of backdated uplifts within 30 days. Providers should not finance statutory wage increases for six or more months while awaiting commissioner decisions.
7	Create a proportionate SME resilience dashboard	CQC and DHSC	Use anonymised Companies House data, provider returns and commissioner intelligence to monitor cash cover, current ratios, working-capital trends, closures, contract handbacks and investment. The dashboard should complement, not duplicate, Market Oversight.

No.	Recommendation	Lead responsibility	Action
8	Introduce an adult social care working-capital protocol	DHSC, NHS England, LGA and provider bodies	Standardise treatment of purchase orders and individual placement agreements, continuation of care beyond an authorisation end date, invoicing and payment routes, invoice evidence, financial assessments, CHC/FNC validation, deferred payment agreements, probate, responsibility disputes and retrospective fee adjustments. Administrative processes should not leave delivered care without a formal route to payment.
9	Provide temporary liquidity where public debt is the cause	DHSC and commissioners	Establish a repayable market-stabilisation route for otherwise viable providers where material overdue public-sector debt threatens payroll or continuity of care. The commissioning body responsible for the debt should bear the financing cost.
10	Measure investment and market confidence	CQC and local authorities	Track investment, refurbishment deferral, admissions, exits and local employment/capacity consequences. Distinguish closures from ownership transfers and use local-association intelligence.

10.1 Fund the cost first

The joint organisations propose that funding settlements explicitly address the cost-of-care shortfall identified in Care England's separate analysis. The £2.36 billion estimate is a modelled funding gap, not a cash balance or unpaid invoice total from this cohort. Workforce obligations and non-pay costs should be costed transparently, with clarity about what additional funding is intended to cover.

Government's commitment to make an additional £4.6 billion available for adult social care in 2028/29, compared with 2025/26, is material. It must be considered alongside employer National Insurance, National Living Wage and wider inflation, as well as the £500 million set aside within that total for the first Fair Pay Agreement. The allocation is not by itself evidence that the actual cost borne by each provider will be met. Clear accountability is required from national funding through council and NHS fee rates to provider receipts.^[25, 26]

10.2 Prompt payment must become a commissioning standard

Prompt payment starts with a route to make a formal claim for care already delivered. The joint organisations therefore propose that every commissioner allow providers to submit an invoice or equivalent formal payment claim, including where a purchase order, individual placement agreement or other funding authorisation has expired but care continues while renewal, eligibility or responsibility is resolved. Commissioner processes should not leave delivered care without a clear payment route. Valid, undisputed claims should then be paid within a consistent maximum of 30 days, with faster scheduled payments where appropriate. Where the Procurement Act 2023 applies, its electronic-invoicing and payment provisions provide the foundation; other arrangements should provide equivalent practical protection. Disputed items should be separated from sums that can be paid promptly, with the undisputed amount paid while the exception is resolved.^[21]

Payment performance should be visible in CQC local-authority assessment evidence and NHS commissioner oversight. National reporting should distinguish care-specific payment time, aged debt, disputed value, retrospective fee arrears, continuing-healthcare and funded-nursing-care debt, deferred-payment balances and responsibility disputes.

10.3 ERA and FPA funding must reach the employer before the liability

Employment-rights reforms create obligations at employer level, while the first Fair Pay Agreement is still to be negotiated and implemented. The joint organisations propose that funding arrangements place money with providers before, or alongside, the associated liability. A national allocation should be traceable through local-authority and NHS commissioning, with differences in service and workforce models reflected in the cost assessment.

At minimum, the first Fair Pay Agreement should include a funded cost model, a national minimum uplift, a timetable that places cash with providers before or alongside the liability, reconciliation where actual workforce exposure differs from assumptions, and a requirement covering NHS as well as local-authority commissioners. Providers should not be expected to borrow to implement a nationally mandated agreement.

10.4 Oversight should identify cumulative SME risk

CQC Market Oversight is based on the difficulty of replacing a provider, not on producing a financial census. The joint organisations propose a complementary aggregate function to monitor smaller providers, using existing data where possible and retaining appropriate confidentiality. It would require an agreed remit, resources, governance and validation rather than simply treating the current accounts sample as a national surveillance system.

The dashboard should not create a burdensome new monthly return for small providers. Much of the data can be drawn from existing accounts, Capacity Tracker, CQC registration, local-authority fee returns and payment compliance notices. A targeted provider survey could fill specific gaps such as payer mix, true debtor days, capital expenditure and access to finance.

10.5 Recognise the local contribution at risk

The joint publishers propose that local-authority market-sustainability plans assess care continuity, local employment, specialist provision and the availability of alternatives when considering financial risk or market exits. CAA, NCA and their member associations can contribute local intelligence; the joint publishers can support consistent national interpretation. Any new indicators should use existing information where possible and distinguish a closure from a transfer that preserves service and jobs.

SECTION ELEVEN

Implementation framework

The recommendations should be translated into a small number of measurable national standards. The purpose is not to centralise every local commissioning decision. It is to create minimum financial disciplines that prevent national and local funding pressure from being transferred invisibly into provider balance sheets.

Table 7. Proposed implementation milestones

Timing	Milestone	Lead
Within 3 months	Agree independent validation, publish the methodology and define proportionate care-specific payment metrics	CE, CAA, NCA and analytical partners; DHSC; CQC
Within 6 months	Baseline local-authority and ICB payment performance; agree a standard invoicing/payment-route, purchase-order and placement-agreement continuation, validation and dispute protocol	DHSC, NHS England, LGA, provider bodies
Before 2027/28 fee setting	Publish national fee timetable and pass-through expectations for ERA costs	DHSC and MHCLG
Before FPA negotiations begin	Publish funded cost model, allocation method and provider receipt mechanism	DHSC, HM Treasury and ASC Negotiating Body
From April 2028 (government's intended date)	Implement the first FPA with funds received by providers in advance of, or contemporaneously with, the liability	Government and commissioners
Annually	Publish SME resilience dashboard and system response where indicators deteriorate	CQC / DHSC

Suggested national indicators

Table 8. A minimum national SME resilience scorecard

Domain	Indicator
Fee adequacy	Average fee vs independently modelled cost; uplift vs workforce and non-pay inflation
Payment	Ability to submit a formal payment claim; average payment days; % within 30 days; value over 60/90 days; dispute resolution time; value of care delivered beyond expired authorisations awaiting renewal
Cash resilience	Mean and median net cash / monthly wage bill
Working capital	True trade-debtor days by payer; current assets less cash / turnover proxy
Investment	Capital expenditure per bed; maintenance backlog; energy and digital investment
Market behaviour	Contract handbacks; placement refusals; closures; sales; change of use

Domain	Indicator
Workforce	Vacancies, turnover, agency use, wage share, sick pay and FPA cost exposure

Governance

A small independent analytical group should oversee the methodology, including financial experts, SME providers, commissioners, CQC, DHSC, Skills for Care and an academic or audit representative. The group should publish definitions, revision policies and confidence ratings. Provider-level information should remain protected; only aggregate and appropriately suppressed results should be published.

The group should report to an existing national forum rather than create a parallel governance structure. The Adult Social Care Operational Resilience Forum or an equivalent DHSC-led body could receive quarterly signals and agree action where the market shows material deterioration.

SECTION TWELVE

Limitations and next-stage research

The accounts provide evidence about this defined cohort, not an audited financial assessment of all SMEs. Limitations must accompany the findings in the report and in external communications, particularly where operating measures are estimated or outcomes are illustrated rather than observed.

Table 9. Methodological limitations

Limitation	Implication
Filed-account lag	Most latest accounts predate 6 April 2025. Later periods capture differing parts of the employer National Insurance change. No calibration period covers the April 2026 SSP reform; 2027 reforms and the intended April 2028 FPA are outside the data. See section 3.6.
Non-aligned periods	Year 1, Year 2 and Year 3 are relative positions, not common national fiscal years.
Small-company filing exemptions	Most main-cohort companies do not publish turnover, wages or detailed operating costs.
Separate calibration cohort	The 165 WITH P&L companies are not a linked subset of the 2,299 main companies and may differ by size, service mix or administrative sophistication.
Modelled wage bill	Wage assumptions apply calibration-cohort averages to employee counts and may not reflect hours, regional pay or service type.
Modelled turnover	Turnover-per-employee assumptions are sensitive to occupancy, dependency and payer mix.
Employee-count basis	The filing measure may be average employees rather than a consistently defined FTE measure.
Broad debtor proxy	The numerator includes non-debtor assets and turnover is estimated. The collection measure is not audited debtor days or a guaranteed upper bound.
No payer or causal attribution	The data cannot distinguish local-authority, NHS, private-pay, probate or other debt and cannot prove why conversion changed.
Outlier sensitivity	Means can be influenced by extreme values; the mean-median gap does not quantify the share of providers in distress.
No full operating-account assessment	The main cohort has no full P&L. Calibration supplies only the stated wage and turnover assumptions; no observed full-cohort net profit or public-contract return is established.
Trajectory limitations	The sensitivity illustration is not a failure forecast and excludes non-pay inflation, tax, capital investment, financing costs, provider differences and unfunded future workforce reform.

Selection and aggregation also matter. Availability of fuller accounts shapes the calibration cohort; availability of comparable records shapes the main cohort. Neither is a random market sample. Means of company ratios differ from ratios of totals, and the company at the median of one indicator need not be the company at the median of another. No inference about national SME profits, aggregate arrears or a rural subgroup is made; the financial analysis covers England only.

The next research programme

- 1** Maintain a locked, version-controlled regular SMART Care Intel extract with stable company matching and a reproducible exclusion log.
- 2** Test how the separate calibration cohort differs by size, geography, ownership, reporting practice and service mix, and validate the transfer of wage and turnover assumptions.
- 3** Obtain actual trade debtors and creditors from a stratified provider sample, split by local authority, NHS and private payer.
- 4** Obtain payer-level income, costs and payment information from a stratified sample to test the relationship between commissioner fees, actual delivery costs and cash resilience.
- 5** Segment the cohort by nursing/residential, older people/working age, bed count, region/authority, CQC rating and public/private funding mix.
- 6** Examine the distribution below different cash-cover thresholds and the effect of account-selection and survivor bias, without treating a threshold alone as a finding of insolvency.
- 7** Examine capital expenditure, maintenance, debt maturity, interest cost and asset quality.
- 8** Repeat the full analysis annually and develop a lighter quarterly signal using new account filings and statutory payment-compliance data.

IN CLOSING

Conclusion

The financial condition of a care provider cannot be understood from its bank balance alone. Cash can rise in pounds while covering less of the wage bill it must support. This analysis identifies that loss of relative headroom across the defined SME cohort.

Across the main cohort, the estimated monthly wage bill increased by 22.3 percent while mean net cash increased by 9.9 percent. Mean cash cover fell from 2.90 to 2.62 months of estimated wages; median cover fell from 1.33 to 1.23 months. Mean current assets other than cash rose by 32.6 percent, while the broad collection proxy lengthened at both mean and median. These are historical findings, not a current cash-flow forecast or proof of one cause.^[4]

The reporting dates make the warning more significant. Most latest accounts end before the April 2025 employer National Insurance changes, and later accounts cover different amounts of the subsequent period. All calibration accounts end before the April 2026 SSP reform. The results therefore do not meaningfully capture the new sick-pay arrangements or measure the further Employment Rights Act changes due from 2027 and the intended April 2028 Fair Pay Agreement. They should not be read as evidence that providers have already absorbed those pressures.^[4]

Priced to Fail identifies the modelled gap between local-authority fees and the cost-of-care benchmark. The Hidden Subsidy explains the additional pricing pressure created when local-authority rates are applied to council-arranged self-funders. The studies are complementary, not interchangeable, and their estimates should not simply be added together. The National Insurance change is already included in Priced to Fail's 2025/26 cost assumptions.^[2, 3]

Where commissioner uplifts fail to meet the cost of care, later workforce obligations and non-pay inflation add to an existing mismatch rather than start from a sustainable baseline. The joint publishers therefore consider recovery in SME cash resilience unlikely without sufficient fee increases, prompt payment or off-setting improvements. Further erosion in subsequent accounts is a reasonable expectation on that basis, not an outcome already established by this dataset. The timing and scale will depend on the reporting periods available and on providers' circumstances and responses.

The implications extend to residents, staff and communities. A locally embedded provider with less room to absorb delayed income or extra cost may have fewer options for investment, recruitment and continuing local provision. These are consequences to monitor, not national impacts quantified by this workbook.

The response is to fund the cost of care, ensure providers can make a formal payment claim for care already delivered, pay valid claims promptly, resolve disputes quickly and pass workforce funding through in full and on time. Commissioners must receive adequate resources and account for what reaches providers. Proportionate SME financial intelligence should identify pressure before choices narrow to reduced investment, restricted admissions or exit.

This report establishes a baseline for repeated analysis. Each update should state the accounting periods covered, assess how later cost changes are reflected and distinguish genuine changes in resilience from changes in the sample. The purpose is to support timely decisions that sustain care, not wait for a predicted failure date.

APPENDIX A

Detailed metrics

Table 10. Analysis summary values

Metric	Year 3	Year 2	Year 1	Comment
Estimated monthly wage bill—mean	£80,680	£89,936	£98,668	+22.3% oldest to latest
Estimated monthly wage bill—median	£72,456	£80,204	£86,073	+18.8%
Net cash—mean	£204,873	£211,284	£225,078	+9.9%
Net cash—median	£94,767	£97,841	£110,361	+16.5%
Net cash / wage—mean	2.895	2.723	2.616	-9.6%
Net cash / wage—median	1.335	1.243	1.228	-8.0%
Current ratio—mean	3.385	5.803	6.166	Outlier-sensitive
Current ratio—median	1.460	1.467	1.495	Limited movement
NCA / wage—mean	2.543	2.674	2.945	Assets increased; cash composition matters
NCA / wage—median	1.160	1.148	1.244	Modest latest increase
Turnover per employee assumption	£47,342	£51,080	£52,996	+11.9%
Estimated annual turnover—mean	£1.845m	£2.062m	£2.187m	+18.5%
Current assets less cash—mean	£394,756	£460,164	£523,493	+32.6%
Collection proxy—mean	81.20 days	83.28 days	88.14 days	+6.93 days
Collection proxy—median	27.75 days	28.58 days	30.70 days	+2.95 days

APPENDIX B

Formula map

Table 11. Formula definitions

Measure	Formula	Data source
Estimated wage bill	Employee count × calibrated average annual wage per employee ÷ 12	Main cohort using P&L calibration
Net cash	Cash less bank loan / overdraft measure	Main cohort
Cash cover	Net cash ÷ estimated monthly wage bill	Main cohort using estimated wage bill
Current ratio	Total current assets ÷ total current liabilities	Main cohort
Net current assets / wage	(Total current assets – total current liabilities) ÷ estimated monthly wage bill	Main cohort using estimated wage bill
Estimated turnover	Employee count × calibrated turnover per employee	Main cohort using P&L calibration
Collection proxy	(Total current assets – cash) ÷ estimated turnover × 365	Main cohort using estimated turnover
Further-delay sensitivity	Comparable increase in days × next-period estimated daily turnover	Sensitivity analysis using main-cohort assumptions

The formula definitions are retained so that the published results can be reproduced from the SME Care Home Financial Resilience Analytical Dataset. The 365-day convention is used for the collection proxy and sensitivity calculations. Exact worksheet and cell references remain in the unpublished analytical dataset and are not reproduced in this publication. ^[4]

APPENDIX C

Glossary

Table 12. Glossary

Term	Definition
ASC	Adult social care.
Cash cover	Net cash expressed as a multiple of the estimated monthly wage bill.
CQC Market Oversight	CQC's statutory monitoring scheme for adult social care providers that would be difficult to replace if they failed.
Current assets	Assets expected to convert into cash or be used within roughly one year, including cash, receivables and prepayments.
Current liabilities	Obligations expected to be paid within roughly one year, including suppliers, tax, wages and short-term debt.
Debtor / receivable	An amount owed to the provider for care or another service already delivered.
Calibration cohort	The separate 165-company WITHP&L population used to derive wage-per-employee and turnover-per-employee assumptions.
ERA	Employment Rights Act 2025.
FPA	Adult Social Care Fair Pay Agreement; government intends the first agreement to take effect in April 2028.
ICB	Integrated care board.
Mean	Arithmetic average; sensitive to extreme values.
Median	The middle value when observations are ordered; less sensitive to extreme values.
Net current assets	Current assets less current liabilities.
Net cash	Cash less borrowing included in the report's simplified measure.
Working capital	Short-term resources needed to fund day-to-day operations between paying costs and receiving income.

APPENDIX D

Publication and evidence record

Report title — The Financial Health of SME Care Homes.

Subtitle — Working capital, cash resilience and the local value of England's independent care homes.

Publication edition — October 2026.

Joint publishers — Care England; Care Association Alliance; National Care Association.

Analytical source — SME Care Home Financial Resilience Analytical Dataset (data extract dated 28 July 2026; unpublished).

Cohorts — 2,299 companies in the main balance-sheet cohort; 165 companies in the separate P&L calibration cohort.

Exclusions — 195 main-cohort records and 3 calibration records, applying the documented comparability and data-quality criteria.

Sector context — approximately 80% is used as a rounded indication of the prevalence of smaller organisations. Skills for Care reports that 84% of adult social care organisations had fewer than 50 employees in 2025/26; this is not a statutory SME count. [8]

This record identifies the publication version and the hierarchy of evidence used. Quantitative findings derive from the locked, unpublished SME Care Home Financial Resilience Analytical Dataset dated 28 July 2026. External sources provide policy and market context and are listed once in the References section. Section 3.6 records the reporting-date coverage; section 8 and the conclusion distinguish observed historical findings from sensitivity illustrations and the joint publishers' conditional outlook. [4]

References

Each source is listed once. Superscript numbers in the report refer to this consolidated reference list. The unpublished analytical dataset is identified generically and is supplied separately to the joint publishers for assurance and repeat analysis.

[1] Care England, SMART Care Intel. <https://smartcareintel.careengland.org.uk/>

[2] Care England, Priced to Fail: The growing funding crisis in adult social care 2022–2026 (2026). <https://smartdirectory.careengland.org.uk/white-papers>

[3] Care England, The Hidden Subsidy (2026). <https://smartdirectory.careengland.org.uk/white-papers>

[4] Care England, SME Care Home Financial Resilience Analytical Dataset (data extract dated 28 July 2026), unpublished analytical workbook.

[5] Association of Directors of Adult Social Services, Spring Survey 2026: Rising adult social care needs leave councils £715 million over budget (14 July 2026). <https://www.adass.org.uk/adass-spring-survey-rising-adult-social-care-needs-leave-councils-715-million-over-budget/>

[6] Department of Health and Social Care, Fair pay agreement process in adult social care: government response (16 July 2026). <https://www.gov.uk/government/consultations/fair-pay-agreement-process-in-adult-social-care/outcome/fair-pay-agreement-process-in-adult-social-care-government-response>

- [7] Care Quality Commission, Market Oversight of adult social care (updated 7 May 2026). <https://www.cqc.org.uk/guidance-regulation/adult-social-care/market-oversight-adult-social-care>
- [8] Skills for Care, The state of the adult social care sector and workforce in England, 2026 (14 October 2026). <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/resources/Reports/National/The-state-of-the-adult-social-care-sector-and-workforce-in-England-2026.pdf>
- [9] RMBI Care Co., news release announcing the sale of its portfolio of 15 care homes across England and Wales (25 February 2026). <https://rcb-bonds.com/wp-content/uploads/2026/02/RMBI-CC-NEWS-RELEASE-25.2.26.pdf>
- [10] Friends of the Elderly, Report and Financial Statements 2022. <https://www.fote.org.uk/wp-content/uploads/2022/11/FotE-financial-statements-2022-signed.pdf>
- [11] Department of Health and Social Care, Adult social care provider statistics, England: quarterly update to August 2026 (3 September 2026). <https://www.gov.uk/government/statistics/adult-social-care-provider-statistics-england-quarterly-update-to-august-2026/adult-social-care-provider-statistics-england-quarterly-update-to-august-2026>
- [12] Care Quality Commission, State of Care 2024/25: Adult social care (24 October 2025). <https://www.cqc.org.uk/publications/major-report/state-care/2024-2025/access/asc>
- [13] Care England and PLMR, The Power of Care: the system behind our society (7 May 2026). <https://www.careengland.org.uk/the-power-of-care-the-system-behind-our-society/>
- [14] Department of Health and Social Care, Care and support statutory guidance, chapter 4: market shaping and commissioning (updated 22 July 2025). <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>
- [15] Care Quality Commission, State of Care 2023/24: Adult social care (25 October 2024). <https://www.cqc.org.uk/publications/major-report/state-care/2023-2024/access/asc>
- [16] Department of Health and Social Care, Market Sustainability and Improvement Fund: care provider fees 2025 to 2026 (21 August 2025). <https://www.gov.uk/government/publications/market-sustainability-and-improvement-fund-2025-to-2026-care-provider-fees>
- [17] HM Revenue & Customs, Employer National Insurance contributions and Employment Allowance changes: Screening Equality Impact Assessment (3 April 2025). <https://www.gov.uk/government/publications/employer-national-insurance-contributions-and-employment-allowance-changes-impact-assessment/employer-national-insurance-contributions-nics-and-employment-allowance-changes-screening-equality-impact-assessment>
- [18] Office for National Statistics, Consumer price inflation, UK: August 2026 (16 September 2026). <https://www.ons.gov.uk/economy/inflationandpriceindices/bulletins/consumerpriceinflation/august2026>
- [19] National Audit Office, Local government financial sustainability (28 February 2025). <https://www.nao.org.uk/reports/local-government-financial-sustainability-2025/>
- [20] NHS England, 2025/26 operating plan position (28 May 2025). <https://www.england.nhs.uk/long-read/2025-26-operating-plan-position/>
- [21] Cabinet Office, Procurement Act 2023 guidance: Electronic invoicing and payment. <https://www.gov.uk/government/publications/procurement-act-2023-guidance-documents-manage-phase/guidance-electronic-invoicing-and-payment-html>

[22] Cabinet Office, Procurement Act 2023 guidance: Payments Compliance Notices. <https://www.gov.uk/government/publications/procurement-act-2023-guidance-documents-manage-phase/guidance-payments-compliance-notices-html>

[23] Department for Business and Trade and Department for Work and Pensions, Statutory Sick Pay changes from 6 April 2026. <https://www.business.gov.uk/campaign/employment-changes/employers/statutory-sick-pay/>; HM Revenue & Customs, April 2026 issue of the Employer Bulletin (Statutory Sick Pay recovery arrangements). <https://www.gov.uk/government/publications/employer-bulletin-april-2026/april-2026-issue-of-the-employer-bulletin>

[24] UK Government, Plan to Make Work Pay and Employment Rights Act: timeline update (25 September 2026). <https://www.gov.uk/government/publications/implementing-the-plan-to-make-work-pay-and-employment-rights-act/plan-to-make-work-pay-and-employment-rights-act-timeline-update>

[25] Ministry of Housing, Communities and Local Government, Additional national available funding for adult social care: final (10 February 2026). <https://www.gov.uk/government/publications/additional-national-available-funding-for-adult-social-care-final/additional-national-available-funding-for-adult-social-care-final>

[26] Department of Health and Social Care, Care workers to be represented in fair pay agreements (16 July 2026). <https://www.gov.uk/government/news/care-workers-to-be-represented-in-fair-pay-agreements>

[27] GOV.UK, Interest on late commercial payments and debt recovery. <https://www.gov.uk/late-commercial-payments-interest-debt-recovery/charging-interest-commercial-debt>



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